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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare recertification survey conducted at your facility on 10/11/10 through 10/15/10, in accordance with 42 CFR Chapter IV Part 483 Requirements for Long Term Care Facilities. The census was 102 residents. The sample size was 21 sampled residents which included 3 closed records. Complaint #NV00026134, regarding allegations of accidents and protective supervision was investigated and substantiated with deficiencies cited. See Tag #F323. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	F 000		
F 164 SS=C	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to ensure clinical records were kept secure.

Findings include:

On 10/13/10, observation revealed the medical records room door was left open. No staff member was present in the medical records office. The open door allowed unsecured accessibility to residents' medical information. An interview with Employee # 5 acknowledged the door should be closed when staff were not present in medical records.

On the initial tour and throughout the survey, a pile of resident records were observed loosely stacked up next to the facility's document shredder out at the nurses' station. The pile of

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F 164	Continued From page 2 resident records was approximately one and a half to two feet high. On 10/12/10 in the afternoon, an interview with Employee # 5, the employee confirmed the resident records' observed at the nurse's station contained personal health care and other information about the residents. The employee indicated the records were stacked by the shredder in anticipation of being shredded. The records could be seen by anyone who had access to the nurse's station, including nurses, nurse's aides, housekeeping and other staff in the facility.	F 164		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and document review, the facility failed to ensure a resident was deemed safe to self-administer medication for 1 of 21 residents (Resident #16). Findings include: Resident #16 Resident #16 was admitted to the facility 2/18/09 following a hypoxic episode caused by a diabetic coma. Other diagnoses included hypertension and depression. Upon admission, the resident was unable to walk and required maximum care. Her present condition showed tremendous	F 176		

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F 176	Continued From page 3 improvement in all areas of her ADLs (Activities of Daily Living). Review of the Insulin (Novolog and Lantus) Medication Administration Record (MAR) for July 2010, showed the notation, "self adm (self administration)" under the recorded times given. The facility policy No. 3.33 (NV), entitled, "Self-Administration of Drugs," stated that the "interdisciplinary team shall meet and assess the resident's ability to self medicate." The policy also directed nursing to assist the resident in the process. The procedure outlined the medications used by the resident to be properly recorded by the facility staff at the time of use on the self administration record and the MAR to indicate self administration. The clinical record would also reflect the resident's response to the program. On 10/14/10, Employee #2 revealed Resident #16 was being educated on how to administer her own insulin in preparation for a less restricted environment. The resident had been an insulin dependent diabetic for a long period of time and had self administered her insulin prior to the hypoxic episode that lead to her dramatic change in condition. Evaluation of her current abilities to self administer was indicated rather than entitling the process as education. The resident's record lacked any assessment of Resident #16's abilities in self administration of her insulin, nor was there any documentation of her response to the self administration program.	F 176		
F 202 SS=D	483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES When the facility transfers or discharges a	F 202		

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resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure the clinical record reflected the necessary transfer to the hospital for one of 21 residents (Resident #18).

Findings include:

Resident #18

Resident #18 was admitted to the facility on 8/9/10, following an acute care hospitalization for pneumonia and sepsis. The clinical record ended with entries on 8/17/10.
"8/17/10 05:07 AM Resident was a little more disoriented at HS (hour of sleep) and when checked his temp he had low grade fever of 99.6, medicated with Tylenol 325 two tabs per standing order and rechecked temp. it went down to 98.2 will continue to monitor. Lung sounds CTA (clear to auscultation) in both upper and lower lobes, no SOB (shortness of breath)
8/17/10 6:45 AM CMP (complete metabolic profile) and CBC (complete blood count) drawn from r (right) forearm attempts x 1, will be sent to (local hospital)."

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F 202	Continued From page 5 There was no further entry as to what happened, what caused the necessary transfer or when the transfer occurred. There was no evidence the physician was informed. There was no discharge or transfer order to the hospital. There was no order for the lab work. On 10/14/10, Employee #2 revealed Resident #18's condition had deteriorated, and he required oxygen. The nurse practitioner was present and Resident #18 was sent to the hospital where he subsequently expired. Employee #2 acknowledged none of this information was documented in the clinical record.	F 202		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review,the facility failed to ensure that medically related social services were provided for 2 of 21 residents (Residents #16 and # 1). Findings include: Resident #16 Resident #16 was admitted to the facility on 2/18/09 following a hypoxic episode caused by a diabetic coma. Other diagnoses included hypertension and depression. Upon admission,	F 250		

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the resident was unable to walk and required maximum care. Her present condition showed tremendous improvement.

On 11/11/09, Resident #16 was evaluated by a psychiatrist. In summary, he stated the resident "presents seemingly competent to resume self guardianship."

A progress note, dated 8/6/10, from social services stated that Resident #16 "does get angry at times with her guardian because she does not like her having all the control over her, especially her money."

A social assessment completed on 8/22/10, described Resident #16 as capable of signing documents on her own behalf, as being mentally alert, social, having a positive attitude, with no personality changes. Resident #16 was also described as independent at times and not being able to handle her money. In summary, it was stated that her guardian was not a good choice. There was no documentation that the psychiatrist's recommendation was being considered.

On 10/14/10, when asked about termination of the guardianship, Employee #6 stated, "they" did not feel the resident was ready.

Resident # 1

Resident #1 had been at the facility since his admission 8/28/09. His primary diagnoses included non-organic psychosis.

Interview with the family revealed Resident #1

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currently was a private pay resident but his funds dwindled to possibly being eligible for Medicaid in the near future.

Observation and interview with the daughter revealed if staff approached Resident #1 and spoke into his left ear or used the white board to communicate, and used touch during the conversation, Resident #1 was more cooperative.

Review of the social service notes for the past year, revealed only two entries for Resident #1 since his admission:
- 12/26/09: "Family cannot care for resident-no plans for discharge."
- 9/24/10: "(Resident) has had several outbursts and has attempted to hit staff. His meds have been adjusted with family approval. (Resident) scored a 13 on the cognitive assessment, this signifies a mild impairment. His decision making abilities are impaired as well. He is a long term resident and is not an elopement risk. Daughter visits daily. "(Resident) is hard of hearing, but (daughter) assists with this. (Resident) receives assistance with all ADLs."

On 10/12/10, Employee #6 revealed she attempted to chart on all residents quarterly but this was not always possible.

Employee #6 also acknowledged she did not discuss financial matters with residents or their families. This was the responsibility of the Business office. Employee #6 had not initiated any applications for Medicaid eligibility for Resident #1. She acknowledged this was information given to families/residents upon admission but not reviewed on a yearly basis to evaluate if the financial situation was unchanged.

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F 250	Continued From page 8 The families were to approach the facility if there were concerns.	F 250		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the assessments accurately reflected the residents'	F 278		

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status in order to maintain or improve abilities and capabilities for 2 of 21 residents (Residents #16 and #1).

Findings include:

Resident #16

Resident #16 was admitted to the facility 2/18/09 following a hypoxic episode caused by a diabetic coma. Other diagnoses included hypertension and depression. Upon admission, the resident was unable to walk and required maximum care. Her present condition showed tremendous improvement.

The quarterly Minimum Data Set (MDS) assessments for 5/17/10 and 8/9/10, identified Resident #16 as being moderately independent in cognition and decision making, needing supervision in transferring, ambulation, dressing and eating with the limited assist of one person in hygiene/bathing. Resident #16 was described as having no limitations in range of motion and being continent of bowel and bladder.

On 10/14/10 at 3:30 PM, Employee #9 revealed Resident #16 transferred and ambulated on her own, selected her own clothes, was able to toilet herself and interacted well with others. In addition, Resident #16 spent regular amounts of time off of the secured unit and walked about the facility grounds on her own.

Documentation in the record indicated the resident set the tables for meal time and poured the coffee for other residents.

It was observed Resident #16 acted as President

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of the Resident Council and made valid and insightful comments. The resident was observed moving from chairs and ambulating unassisted. The resident participated in multiple activities.

The facility lacked an accurate assessment of the resident which provided the necessary data for effective development of care plans and the provision of the appropriate delivery of care icluding than of a less restrictive environment.

Resident #1

Resident #1 had been at the facility since 9/28/09, initially as a respite care intervention, and then a long term solution. His diagnoses include non-organic psychosis, loss of hearing and bilateral cataracts.

Observation during the survey revealed Resident #1 could not hear well. Family members used a white board with black marker to write instructions so Resident #1 would understand and follow instructions better. The resident could not hear well out of his right ear, and would request staff to talk into his left ear. The resident's family confirmed that he was blind in the left eye due to cataracts, but could see the white board with his right eye.

Review of the admission comprehensive Minimum Data Set (MDS) assessments(completed 10/5/09) revealed Resident #1 was identified as having only minimal difficulty hearing, when not in a quiet setting. This remained unchanged at the last comprehensive MDS completed 9/24/10, which was a significant change. Neither MDS assessments indicated that other communication

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F 278	Continued From page 11 techniques were to be used for hearing, such as the white board. Resident #1 was also assessed on admission as having moderately impaired vision, but on 9/24/10, he was assessed as having no vision problems, being able to see regular newspaper print. An interview with Employee #3 acknowledged the MDS assessments did not accurately reflect Resident #1's vision and hearing sensory status.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by:	F 279		

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Based on record review, and staff interview, the facility failed to develop comprehensive care plans designed to maintain/enhance the highest physical, mental and psychosocial abilities for 1 of 21 residents with a urinary device (Resident # 6), for 1 of 21 residents with psychosocial needs (Resident #16) and for 1 of 21 residents with behavioral and communication needs (Resident #1).

Findings include:

Resident #6

Resident #6 was admitted to the facility on 9/10/10. Diagnoses included dementia, hypertension, and osteoarthritis. The resident had Cancer of the Prostate in the 1990s with removal of his prostate. The surgery contributed to the destruction of his urinary sphincter, resulting in urinary incontinency. Several years later, an artifical sphincter was created, by which the bladder could be emptied by depressing a "button" located beneath his scrotum. If the bladder was not emptied, the resident would experience leakage of urine.

Upon admission, Resident #6 was able to depress the "button" with prompting. The resident's wife inserviced the staff on the secure unit as to how the device worked and where the button was located. She explained that if a schedule was not established and the bladder was full, leakage would occur.

Located in the record was a form entitled "Toileting Schedule," indicating habit training and scheduled voiding. The goal was to be incontinent of bladder less than four times daily

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without symptoms of urinary retention. The form was not dated and indicated Resident #6 was toileted at 7:00 AM, 9:00 AM, 11:00 AM, 1:00 PM, 4:00 PM, 7:00 PM, and 9:00 PM. The dates covered were from 1st to the 12th. The month was unknown. There was no documentation from 7:00 AM to 4:00 PM on the 4th, 10th or 14th. Documentation indicated that there were periods of incontinences from three to five times per day. There was no other documentation on the form.

On 10/14/10 at 3:30pm, Employee #9 indicated Resident #6 wore adult incontinency pads during the day, but not at night. Employee #9 also indicated the resident would depress the button with prompting.

Review of a care plan for Resident #6, identified the problem as use of an artifical sphincter for urination with frequent episodes of incontinency with a goal of less than four incontinency episodes per day. Approaches included encouraging the resident to activate the sphincter, if unable staff to assist, wearing of briefs during daylight hours only, take to bathroom between scheduled times as needed or requested, take to bathroom per toileting schedule found on toileting record, and assist with all bathroom use, squeeze testicles to open sphincter.

A facility handout entitled, "Bowel and Bladder Incontinence" stated scheduled voiding was usually every three to four hours while awake, while habit training was with the intervals based on the resident's usual voiding schedule or pattern. The Toileting Schedule did not indicate the frequency of voiding other than the times being circled on the form, which was every two hours and then every three hours, not every three

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to four hours as indicated in the handout. As the Toileting Schedule was not dated and was incomplete, it was not known if it was current or in effect. This made it difficult to determine if the care plan was accurate.

The approach indicating how to activate the sphincter was to squeeze the testicles. Both the training the wife gave to the staff and the AMS Artifical Urinary Sphincter form contained in the resident's record, indicated that the activation button was located in and behind the scrotum. The directions were to squeeze the lower part of the pump, not the testicles as the care plan indicated.

The resident's wife also stated that if the the bladder were not emptied on a schedule, there would be leakage of urine. The care plan for urinary incontinency was not complete, accurate or comprehensive.

Resident #16

Resident #16 was admitted to the facility 2/18/09 following a hypoxic episode caused by a diabetic coma. Other diagnoses included hypertension and depression. Upon admission, the resident was unable to walk and required maximum care. Her present condition showed tremendous improvement.

The resident was described in the discharge assessment dated 5/13/10 as being highly motivated toward a discharge plan, needing training for glucose testing and treatment, feeling anxious about not doing well off of the unit, but being able to answer all questions on the cognitive assessment.

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F 279	Continued From page 15 Staff indicated that Resident #16 had been moved to the assisted living unit for a short period of time, but failed to be responsible in eating properly, checking her blood sugars and taking her medication properly. Resident #16 did not appear to need the confinement of the secured unit except for a personal sense of comfort. There was no evidence of care planning in the resident's record to facilitate or foster a greater degree of independency, or to help in the transition to a lower level of care. Resident #1 Resident #1 had been at the facility since 9/28/09, initially as a respite care intervention, and then a long term solution. His diagnoses include non-organic psychosis, loss of hearing and bilateral cataracts. Observation during the survey revealed Resident #1 could not hear well. Family members used a white board with black marker to write instructions so Resident #1 would understand and follow instructions better. The resident could not hear well out of his right ear, and would request staff to talk into his left ear. The family confirmed Resident #1 was blind in the left eye due to cataracts, but could see the white board with his right eye. It was also observed that speaking in a normal tone voice, close to his left ear as well as touching Resident #1 on his shoulder or hand would assist him to focus on the speaker. Review of the care plans revealed staff described Resident #1 as angry, cranky, refused care and	F 279		

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F 279	Continued From page 16 had outbursts of behavior. He was currently treated with Seroquel. Care plans had the general statement of "Use kind, calm approach. He appreciates being respected." There was no specific instructions as what kind, calm approach should be used. An interview with Employee #3 acknowledged the care plan was not specific regarding specific interventions with communication methods such as the use of the white board, speaking into Resident #1's left ear, or the use of touch, would assist with decreasing behaviors related misunderstanding or lack or respect.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and document review, the facility failed to ensure a decline of a resident's condition was accurately assessed and documented for one of 21 residents (Resident #18). Findings include: The Nevada Nurse Practice Act 632.212 defined the duties and competency required of a registered nurse (RN). This included that the RN should implement and assist with providing necessary care, document interventions and responses, make judgement decisions and modify care, communicate significant changes of patient status.	F 281		

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Resident #18

Resident #18 was admitted to the facility on 8/9/10, following an acute care hospitalization for pneumonia and sepsis. The clinical record ended with entries on 8/17/10:
"8/17/10 05:07 AM Resident was a little more disoriented at HS (hour of sleep) and when checked his temp he had low grade fever of 99.6, medicated with Tylenol 325 two tabs per standing order and rechecked temp. it went down to 98.2 will continue to monitor. Lung sounds CTA (clear to auscultation) in both upper and lower lobes, no SOB (shortness of breath)
8/17/10 6:45 AM CMP (complete metabolic profile) and CBC (complete blood count) drawn from r (right) forearm attempts x 1, will be sent to (local hospital)."

There was no further entry as to what happened, what caused the necessary transfer or when the transfer occurred. There was no evidence the physician was informed. There was no discharge or transfer order to the hospital. There was no order for the lab work.

On 10/14/10, Employee #2 revealed Resident #18's condition had deteriorated, and he required oxygen. The nurse practitioner was present and Resident #18 was sent to the hospital where he subsequently expired. Employee #2 acknowledged the RNs did not demonstrate appropriate documentation to demonstrate Resident #18's significant change in status was recognized, appropriate nursing care implemented, and documentation of interventions and responses. There was no evidence the physician was informed or any

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F 281	Continued From page 18 interim orders documented to demonstrate the RN was communicating significant changes of patient status or providing judgement decisions and modifying care. Employee #2 acknowledged the RN should have documented when Resident #18 left the facility and what his condition was at the time of discharge. Employee #2 acknowledged Resident #18 expired in the hospital.	F 281		
F 283 SS=D	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a recapitulation for anticipated discharge of a resident's stay was completed for 1 of 21 residents (Resident #20). Findings include: Resident #20 Resident #20 was admitted to the facility on 4/4/10 and was later discharged on 10/8/10. Review of the resident's medical record failed to reveal a discharge summary and/or recapitulation of the resident's stay by their physician.	F 283		

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F 283	Continued From page 19 On 10/13/10 in the morning, Employee #2 confirmed a recapitulation of the resident's stay had not been completed.	F 283		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to help 1 of 21 residents obtain the highest practical level of physical, mental and psychosocial well being by providing an accurate assessment, formulating a comprehensive and inclusive care plan and revising the interventions as indicated (Resident #16). Findings include: Resident #16 Resident #16 was admitted to the facility 2/18/09 following a hypoxic episode caused by a diabetic coma. Other diagnoses included hypertension and depression. Upon admission, the resident was unable to walk and required maximum care. Her present condition showed tremendous improvement. The quarterly Minimum Data Set (MDS)	F 309		

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assessments for 5/17/10 and 8/9/10 identified Resident #16 as being moderately independent in cognition and decision making, needing supervision in transferring, ambulation, dressing and eating with the limited assist of one person in hygiene/bathing. The resident was described as having no limitations in range of motion and being continent of bowel and bladder. However, care plans for activities of daily living contained approaches that dealt with set up assistance and oversight from staff.

On 10/14/10 at 3:30 PM, Employee #9 described Resident #16 as transferring and ambulating on her own, picking out her own clothes, able to toilet herself and interacting well with others. In addition, the resident spent regular amounts of time off of the secured unit and walked about the facility grounds on her own.

Documentation in the record indicated Resident #16 set the tables for meal time and poured the coffee for other residents.

It was observed Resident #16 acted as President of the Resident Council, making valid and insightful comments. The resident was observed moving from chairs and ambulating unassisted. The resident participated in multiple activities.

Resident #16 was described in the discharge assessment dated 5/13/10 as being highly motivated toward a discharge plan, needing training for glucose testing and treatment, feeling anxious about not doing well off of the unit, but being able to answer all questions on the cognitive assessment. Staff indicated that she was moved to the assisted living unit for a short period of time, but failed to be responsible in

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F 309	Continued From page 21 eating properly, checking her blood sugars and taking her medication properly. Resident #16 did not appear to need the confinement of the secured unit except for personal sense of comfort. There was no evidence of care planning in the resident record to facilitate or foster a greater degree of independence, or to help in the transition to a lower level of care. There was no evidence Resident #16 was encouraged or care planned to make gradual and continuous efforts towards greater levels of self sufficiency and reliance. See Tag F279	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a wheel chair was properly secured when transporting a resident in the facility's transportation van for 1 of 21 residents (Resident #20). Findings include: Investigation of complaint number NV00026134, regarding an alleged fall and resident safety while being transported, for Resident #20, was	F 323		

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investigated during the course of the facility survey.

On 10/11/10, Employee #1 indicated they had completed a self-report to the State and investigated an incident involving Resident #20 who had sustained an injury as a result of not being secured during transportation. The employee indicated the wheel chair had been secured in the transportation van and the Transportation Aide had not secured the resident with the lap-shoulder safety belt. The employee further indicated the resident had tipped to the side while in the wheel chair when the driver had turned a corner, resulting in the resident bumping the head and hand. The employee also indicated the Transportation Aide involved in the incident had been terminated following the investigation.

On 10/12/10 at 8:35 AM, Employee #11 indicated he was responsible for training the transportation aides in using the van, including securing the wheel chairs and the residents. The employee recalled the incident involving Resident #20, and confirmed the lap-shoulder safety belt was broken at the time of the incident and had not been used to secure the resident when transported. The employee further indicated the broken lap-shoulder safety belt was repaired within two days of the incident and during that time the facility purposely did not transport any wheel chair residents in the van.

On 10/12/10 at 9:12 AM, an inspection of the facility's transportation van was conducted and was completed in the presence of the Employee #11 and Employee #12. There were two designated areas in the van for wheel chair placement. The van was equipped with two

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lap-shoulder safety belts and a total of four tie-downs (two per chair). During the inspection Employee #12 demonstrated how a wheel chair was secured in the van and how a resident being transported in a wheel chair was secured with the lap-shoulder safety belt. Employee #12 secured the wheel chair with two tie-down anchors, one anchor was secured underneath the center of the chair and the other anchor to one of the front wheels. Employee #12 was careful to check both the placement of the tie-downs and the tension. Employee #11 participated by sitting in the wheel chair and was secured in with the lap-shoulder safety belt. With Employee #11 seated and belted in, the wheel chair was able to easily tip from side-to-side. Employee #11 confirmed Employee #12 had used the tie-downs as trained and agreed during the demonstration that the wheel chair was not very stable.

Following the demonstration, Employee #11 was asked for a copy of the manufacturer's instructions for securing the wheel chair in the van. Once located, the instructions were reviewed with the employee. The instructions indicated that each wheel chair should be secured with a tie-down (one for each wheel section, which would require a total of four tie-down anchors per wheel chair). The instructions were clearly outlined with step-by-step directions and included detailed pictures. The employee indicated this was the first time he had seen the instructions which had not been included in the training he provided to staff.

Inspection of the van, the demonstration and review of the manufacturer's instructions revealed there was not an adequate number of tie-down

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anchors and the wheel chair was not being secured properly. While the transportation van could accommodate two wheel chairs there were only a total of four tie-down anchors, staff were only using two anchors per wheel chair to secure them in place.

Review of Resident #20's medical record, revealed a statement completed by a Transportation Aide on 6/25/10 at 9:00 AM. The Aide, who was in attendance at the time of the incident, documented he had secured the resident's wheel chair in the transportation van using the floor locks on the front and back of the resident's wheel chair. The Aide indicated that after stopping at a red light, he turned when the light turned green and upon hearing a noise he saw the resident in her wheel chair tilted to the right and the resident's head was leaning on the wheel chair lift. The Aide further indicated he pulled over, uprighted the resident, checked for injury, and noted there was no bleeding from the resident's head, but there was some bleeding from her finger. The Aide had called the facility and spoke with a registered nurse for further direction. The resident was later evaluated at the emergency room.

The Transportation Aide involved in the incident no longer worked at the facility, and was not able to be reached for interview.

The facility failed to: 1) identify and ensure adequate safety equipment (tie-down/floor anchors) was installed in the transportation van prior to use, 2) maintain safety equipment (lap-shoulder safety belt) in working order to prevent accidents and ensure resident safety, 3) to identify and ensure appropriate training and

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F 323	Continued From page 25 information was given to the instructor, and 4) to ensure the instructor provided correct information and instruction to staff. Complaint #NV00026134	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents identified at risk for weight loss were accurately and consistently having their meal consumption recorded for 4 of 21 residents (Residents #1, #2, #3, #19). Findings include: Review of four residents' documented meal intake records for the past 30 days revealed approximately 1/4 to 1/3 of the meals were absent of any food intake or other indicators such as "refused," "out of facility," or "none." The meal intake record reviews also revealed duplicate meal entries with the same percentage of intake.	F 325		

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All four residents resided on the same hall.

Resident #1

Resident #1 was identified for nutritional risk and weight loss, related to colon cancer and poor appetite. Resident #1 was 64 inches tall and currently weighed 97 pounds. Review of his clinical record revealed a documented weight loss of three to four pounds in July, 2010. Review of his food intake records on 10/12/10, revealed that 20 of the 90 meals for the past 30 days were not recorded. Three meals had duplicate charting, with one entry indicating a food intake of 75-100% of a meal, and then a second entry of less than 25% for the same meal. This altered approximately 33% of his meals.

Resident #2

Resident #2 was identified with a history of weight loss, and had difficulty swallowing. Review of the resident's food intake records on 10/12/10, revealed that 16 of 90 meals for the past 30 days were not recorded. In addition, six meals had duplicate charting, with two meal entries indicating a 76-100% intake and then changed to less than 25% intake for the same meal. This altered approximately 32% of the resident's meals.

Resident #3

Resident #3 was identified for risk of dehydration and skin breakdown. Review of his food intake records on 10/12/10, revealed 17 of 90 meals for the past 30 days were not recorded. In addition Resident #3 had three meal entries that were duplicates. This altered approximately 30% of his

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F 325	Continued From page 27 meals. Resident #19 Resident #19 was care planned for increased nutritional risk due to her diagnosis of diabetes. Review of her food intake records on 10/12/10, revealed 15 of 90 meals for the past 30 days were not recorded. In addition Resident #19 had three meal entries that were duplicates. This altered approximately 28% of her meals. On 10/14/10, Employee #10 confirmed per telephone she did not have time to make sure that each meal for each resident was documented. Employee #10 acknowledged she did a general review of meal consumption to see what % of meal intake was most prevalent. Employee #10 acknowledged duplicate entries, or lack of entries would alter her assessments, resulting in possible higher assumptions of intake. Employee #10 confirmed that poor nutrition status or even resulting weight loss for the above four residents would be hard to assess whether it was unavoidable or not because of the lack of data, and interventions. Employee #10 acknowledged she was not aware of the lack of documentation of meal intake. An interview with Employee #1 confirmed the clinical records of these four residents indicated the staff did not document all meals. Employee #1 confirmed that residents at risk for skin breakdown, weight loss or poor nutrition would not be sufficiently monitored, and the facility could not ensure these adverse events were unavoidable, if meals were not documented.	F 325		
F 356	483.30(e) POSTED NURSE STAFFING	F 356		

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F 356 SS=D	Continued From page 28 INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure nurse staffing hours were posted and placed in a prominent area, where the information could be seen and read by residents	F 356		

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F 356	Continued From page 29 and visitors. Findings include: Observation during the initial tour of the facility on 10/11/10, failed to reveal the posting of nursing hours as required. On the afternoon of 10/12/10, the nursing hours were observed posted at the nurses' station on two separate walls. Both signs were positioned approximately 6 feet high up on the walls. The signs were on an eight by eleven (8" x 11") white sheet of paper which blended into the wall color. The signs did not stand out and were not at a level in which a resident or visitor, especially those in a wheel chair, would have noticed or been able to read them. On 10/14/10, Employee #1 agreed the signs did not stand out and were not placed in a convenient location for residents and visitors to access.	F 356		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	F 371		

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F 371	Continued From page 30 failed to ensure proper sanitary conditions in the dietary department. Findings include: An inspection of the kitchen on 10/11/10 revealed the following: 1. Two garbage containers in the kitchen had their lids removed during dinner meal preparation. 2. An inspection of the walk-in freezer revealed raw meat stored above other food products such as onion rings and bread. 3. Employee # 4 was observed all day without a protective head covering. The employee's hair was about an inch long. The employee indicated he normally shaved his head or wore a cap, but had forgotten his cap that day.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431		

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locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation, the facility failed to properly label biologicals and drugs with the expiration date and to properly maintain the over the counter stock of medications.

Findings include:

Observation of the medication room at 10:05 AM on 10/13/10 revealed:
- An open vial of injectable testing material (PPD) was noted to be opened and partially used, but there was no date on the label to indicate when the multi dose vial had been opened.

- A vial of injectable Methotrexate, which was ordered for a specific patient, was also opened and had been partially used. There was no date indicating when the multi dose vial had been opened.

Nursing staff indicated facility policy was to date

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F 431	Continued From page 32 vials when opened so the vials could be disposed of 28 days after opening. - In the section of the medication room used for the over-the-counter stock items, two bottles of Mineral Oil that had been partially used and returned to the stock. Three opened tubes of Dr. Sheffield's Muscle Rub ointment had been returned to the general stock. Once used the item should not be returned to the general stock supply.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441		

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F 441	Continued From page 33 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the maintenance of an effective Infection Control program designed to provide safe and sanitary environment and transmission of disease and/or infection, to include 1) Observation of proper infection control procedures during bio-hazard clean up, 2) Prepared and dirty food items placed on the same cart, 3) Tracking infections, 4) Clean, unbroken food prep areas and 5) Division of clean and dirty storage areas. The facility failed to ensure proper recognition and treatment interventions for residents who have tested positive for Tuberculosis (Resident #19). Findings include: The infection control policy identified the department heads for dietary, housekeeping/maintenance, and nursing, as well as the facility Administrator, Medical Director and Pharmacist were the infection control committee members. This committee was responsible to implement policies to decrease infections, and responsible for surveillance. During the survey, it	F 441		

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was revealed in interview that each department head was responsible for infection control inservices within their own department, but there was no inclusive infection control training of the facility as a whole. This resulted in no interdisciplinary monitoring of possible breaks of infection control practices or coordination of staff during a possible infection control disaster.

On 10/12/10 at 7:15 AM, multiple staff were observed involved in a water clean-up at the end of the 300 hall, between the dining area and residents' rooms. Approximately three to four housekeepers, one using a wet-vac, and approximately two to three certified nursing assistants were using bedspreads, blankets and towels to mop up a water spill extending from one semi-private room, across the hall and into another semi-private room. There was approximately 1/4 to 1/2 inch of water on the floor. Also observed was a kitchen staff member (Employee #4) assisting with the clean-up. It was reported a toilet had overflowed, after a resident had a bowel movement and may have used too much paper. Staff thought the toilet had overflowed about 6:45 AM. Most of the residents had already arrived in the dining room before the flooding.

For the next 15 minutes of observation:
1) the kitchen staff member (Employee #4) used a mop and bucket normally used by housekeeping to mop up water. Employee #4 was not wearing gloves. The mop bucket was one that had a mop squeezing device that was hand operated.
2) the housekeeping staff and nursing assistants picked up the dripping blankets, spreads, towels and carried them to the heavy plastic dirty linen

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wheeled receptacles. It was observed that the staff were walking through the water. The dripping linen did drip on the top of the staff's shoes.
3) Employee #4 moved saturated linen with his hands while he mopped. He also picked up saturated linen with his un-gloved hands to put into the receptacles.
4) One random resident who was in a wheel chair traveled through the water spill twice, once to leave the dining area and once to return.
5) When Employee #4 was inforomed he would need to wash his hands and put gloves on if he was going to assist with the clean up, Employee #4 replied he, "would go back to the kitchen to do this task." He was also informed that before he returned to the kitchen Employee #4 needed to change his clothes because of possible contamination. These interventions were reported to Employee #1 and Employee #2.
6) Housekeeping staff and nursing assistants were also observed pushing the saturated linens down into the plastic receptacles to make more room for more linen. It was also observed that the dirty water was dripping on the outside of the receptacles. These receptacles were then wheeled through the hall and into the central hall for both laundry and kitchen access.

Employee #1 and #2 acknowledged Employee #4 should not have been assisting, due to his responsibilities in the kitchen, and high risk of food contamination to all the residents.

Employee #1 and #2 confirmed residents should have been stopped from traveling through the spill due to safety issues as well as infection control concerns of resident's hands contacting the wheels of the wheel chair. The wheels of the

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wheelchair came in contact with the water, and the resident manually wheeled the chair, thereby contaminating her hands with the water.

Employee #1 and #2 confirmed the same toilet had overflowed three other times, but the time frame could not be determined.

The breakfast observation on 10/13/10 at 7:30 AM, revealed a multi-shelved cart. On the top shelf were unserved food: three bowls of cereal, two glasses of what appeared to be apple juice and two glasses of what appeared to be orange juice. There was one glass that appeared to be a strawberry shake. All of these food servings were uncovered although there was a piece of plastic wrap laying beside the food servings. A nursing assistant brought a tray with the remains of a resident's breakfast to the cart and placed it next to the unserved food. The nursing assistant then covered the unserved food with the plastic wrap and confirmed that the unserved food was for if a resident wanted additional portions.

Interviews with the two infection control coordinators revealed that Employee # 2 received data regarding infections and interventions, and Employee #1 compiled data for tracking. Review of the facility's tracking information revealed a color code system to identify respiratory, urinary, and other infections as a visual guide to show possible outbreaks. September's infection tracking revealed that a "conjunctivitis" (a potentially contagious eye infection) was coded as a respiratory infection. Attempts by Employee #1 to demonstrate this was a one-time error revealed that since January 2010, conjunctivitis was identified as a respiratory infection.

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An interview with Employee #1 revealed this task of color coding infections had been delegated to an administrative assistant. An interview with Employee #7 confirmed she performed the color coding. Employee #7 acknowledged she had not received any training and thought conjunctivitis was a head cold type respiratory infection. Employee #7 stated she used the previous entries as a guide to what colors the various infections should be.

Interviews with the infection control coordinators confirmed that the facility used CDC guidelines but review of the infection control policies revealed no references to CDC.

Resident #19

Review of resident tuberculosis testing and results revealed that Resident #19 was negative for Tuberculosis (TB) in 2008 and 2009. On 1/13/10, Resident #19 received a TB skin test. There was no evidence the skin test was read, however an undated/unsigned note on the form indicated Resident #19 was a "converter". There was no subsequent chest X-ray to rule out a possible active disease. Review of her history and physical did reveal Resident #19 had TB in the late 1940's. A physician's progress note on 1/15/10, indicated the resident had a three centimeter weal following a TB skin test administered 1/11/10 (dates didn't match with documentation). The physician instructed staff not to administer TB skin tests in the future, but did not write an order for a chest X-ray. There was no indication the physician had been informed the previous two years, Resident #19 had been negative for her skin tests.

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An interview with Employee #2, revealed the facility could not explain why Resident #19 tested positive in 2010 after two years of testing negative. Employee #2 could not explain why Resident #19 was even tested as review of her care plan dated 1/30/07, which indicated Resident #19 should be monitored for signs and symptoms of TB, and receive a chest X-ray as needed.

An inspection of the satellite kitchens on the units revealed broken and chipped formica on the food serving counters on all the units. The counters could not be properly sanitized.

During observation of the medication room on 10/13/10 at 10:05 AM, it was noted that a refrigerator for lab specimens and a centrifuge for spinning down blood specimens was located in the corner of the medication room, which should have been designated as a "clean" area. Located above the centrifuge was a cabinet with rectal supplies and located below the centrifuge were drawers containing syringes and needles.

The specimen refrigerator and the centrifuge should be located in a "dirty" area so as not to cross contaminate or possibly spread infection in a clean areas.

During observation of the breakfast meal on 10/12/10, it was noted that a soiled buffer pad used with floor buffing equipment was stored under the hand washing sink in the pantry located at the end of the 100 Hall. The pantry was an area that was utilized to serve meals for the residents of that hall. Housekeeping equipment should not be stored in the meal preparation/serving area.

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F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and document review, the facility failed to ensure that clinical records were complete and accurate in 2 of 21 residents (Resident #19 and #18), with unnoted interim orders and in 1 of 21 residents with a discharge and readmission back to the facility (Resident #16). Findings include: Review of Resident #19's record revealed a progress note entry on 1/15/10, from a physician indicating he did not want Resident #19 to receive any more Tuberculosis skin tests due to a past history of Tuberculosis. This was not noted in any way to indicate nursing staff were aware of the request. There were no interim orders written to reflect this physician's request. Review of Resident #18's clinical record revealed	F 514		

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a note on a lab result indicating the resident was to be sent to the hospital. The entry was not dated or signed by the individual who wrote it. This was not noted in any way to indicate nursing staff were aware of the request. There were no interim orders written to reflect this request.

An interview with Employee #2 regarding both of these events acknowledged that:
1) Resident # 19 was not to receive any further TB testing because of her history.
2) Resident # 18 was sent to the hospital on 8/17/10, and that the undated, unsigned entry on the lab results was written on 8/17/10, by the nurse practitioner.

Employee #2 did confirm there were no physician orders written to reflect that nursing was aware of the changes. It was also confirmed the facility did not have any policy regarding interim orders written on sources other than physician order sheets.

Resident #16

Resident #16 was admitted to the facility 2/18/09 following a hypoxic episode caused by a diabetic coma. Other diagnoses included hypertension and depression. Upon admission, the resident was unable to walk and required maximum care. Her present condition showed tremendous improvement.

Notes from the social worker and Special Care Unit Coordinator and in conversations with other staff, it was discovered that Resident #16 was moved from the Special Care Unit to a new assisted living section which was attached to the facility. This move took place sometime this past

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F 514	Continued From page 41 summer and the change lasted approximately one week. No documentation of the transition to the assisted living section or the movement back to the special care unit could be located in the resident's record in the form of physician's orders, progress notes, medication administration records, care plans, discharge summaries or new admission records. Employee #2 concurred that there was no documentation regarding the transition could be located in the record.	F 514		